OMB Number: 2900-0517
Estimated burden: 4 minutes

Department of Veterans Affairs

CHAMPVA CLAIM FORM

CHAMPVA CENTER PO BOX 65024 DENVER CO 80206-5024 800-733-8387

WHO FILLS OUT THIS FORM – Patient, sponsor or guardian. Completion of form is mandatory except for provider submitted claims.

TIMELY FILING REQUIREMENT – Claims must be filed within one year of the date of service.

OTHER HEALTH INSURANCE (OHI) – Attach the OHI's Explanation of Benefits (EOB) to the provider's itemized billing statement(s). Dates of service and provider charges on EOB must match billing statements.

ITEMIZED BILLING STATEMENTS – An itemized statement must be attached and contain:

- Patient name, date of birth, and CHAMPVA Authorization Card (A-Card) number;
- Provider name, degree, tax identification number (TIN); address and telephone number;
- Service dates, itemized charges and appropriate procedure/diagnosis codes for each service (i.e., CPT-4, HCPCS, and ICD-9-CM codes respectively), including narrative descriptions. (Pharmacy claims are to include name, quantity, strength and NDC of each drug.)

SECTION I – PATIENT INFORMATION

1. LAST NAME	2. FIRST NAME	3. AUTHORIZATION CARD NO
		A

4. STREET ADDRESS	5. SOCIAL SECURITY NUMBER
	– –

6. CITY	7 STATE	8. ZIP CODE	9. TELEPHONE NUMBER
			( ) –

SECTION II – OTHER HEALTH INSURANCE INFORMATION (By law, other coverage must be reported. Except for CHAMPVA Supplemental policies, CHAMPVA is always the secondary payor.

10. WAS TREATMENT FOR A WORK-RELATED INJURY OR CONDITION ☐ YES ☐ NO	14A. POLICY/PROGRAM NAME	
11. WAS TREATMENT RELATED TO AN INJURY OR ACCIDENT OUTSIDE OF WORK ☐ YES ☐ NO	14B. POLICY NUMBER	14C. TELEPHONE NUMBER ( ) –
12. IS PATIENT COVERED BY ANY OTHER HEALTH INSURANCE PLAN OR PROGRAM, TO INCLUDE COVERAGE THROUGH A FAMILY MEMBER CHAMPVA SUPPLEMENTAL INSURANCE DOES NOT APPLY ☐ YES (complete items 13 and 14) ☐ NO (proceed to item 15)	14D. POLICY/PROGRAM NAME	
	14E. POLICY NUMBER	14F. TELEPHONE NUMBER ( ) –

13. TYPE OF COVERAGE (check all that apply and complete item 14)
☐ EMPLOYMENT (group) ☐ PRIVATE (non-group) ☐ MEDICARE ☐ SUPPLEMENTAL ☐ OTHER (specify)

SECTION III – SPONSOR INFORMATION

15. LAST NAME	16. FIRST NAME	17. SOCIAL SECURITY NUMBER
		– –

SECTION IV – CLAIMANT CERTIFICATION (Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious, or fraudulent statement or claim)

RELEASE OF MEDICAL INFORMATION: Signature in this Section authorizes the patient's providers to release medical record documentation related to the services associated with this claim. This consent pertains to all medical records, including records related to treatment for psychological and psychiatric conditions, drug and alcohol abuse, acquired immune deficiency syndrome, human immunodeficiency virus infection, and sickle cell disease.

I CERTIFY THAT THE ABOVE STATEMENTS AND ATTACHMENTS ARE CORRECT AND REPRESENT ACTUAL SERVICES, DATES, AND FEES CHARGED

18. SIGNATURE	19. RELATIONSHIP TO PATIENT	20. DATE

PRIVACY ACT: This information is solicited under Title 38 USC; 44 USC 3101; 10 USC 1079 and 1086; 41 CFR 101 and Executive Order 9397, to evaluate eligibility and coordinate benefits when other health insurance exists. Disclosure is voluntary, but failure to provide the information may result in delay and/or denial of future CHAMPVA benefit claims. Failure to furnish this information will have no adverse impact on any other benefits to which you may be entitled.

PAPERWORK REDUCTION ACT INFORMATION: Public reporting burden for this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to VA Clearance Officer (045A4), 810 Vermont Avenue NW, Washington DC 20420.